IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

IJKG, LLC, IJKG PROPCO LLC and IJKG OPCO LLC d/b/a CAREPOINT HEALTH — BAYONNE MEDICAL CENTER, HUDSON HOSPITAL OPCO LLC d/b/a CAREPOINT HEALTH - CHRIST HOSPITAL, AND HUMC OPCO LLC d/b/a CAREPOINT HEALTH — HOBOKEN UNIVERSITY MEDICAL CENTER, Plaintiffs, vs. UNITED HEALTHCARE SERVICES, INC., OPTUMINSIGHT, INC. AND UNITEDHEALTH GROUP, INC., Defendants.	CIV. ACTION NO.: **COMPLAINT AND JURY DEMAND**

COMPLAINT

Plaintiffs IJKG, LLC, IJKG PROPCO LLC and IJKG OPCO LLC d/b/a CarePoint Health – Bayonne Medical Center ("BMC"), Hudson Hospital OPCO LLC d/b/a CarePoint Health – Christ Hospital ("CH"), and HUMC OPCO LLC d/b/a CarePoint Health – Hoboken University Medical Center ("HUMC") (collectively, the "CarePoint Hospitals") file this Complaint against Defendants United HealthCare Services, Inc. ("UHS"), OptumInsight, Inc. ("Optum") and UnitedHealth Group, Inc. ("UHG") (collectively, "United" or "Defendants"), and allege as follows:

I. INTRODUCTION

1. The CarePoint Hospitals file this Complaint against Defendants based on Defendants' pattern of paying claims in full for medically necessary treatment submitted to Defendants for reimbursement, and then, many months and in some cases years later, making improper repayment demands and unauthorized attempts to recoup nearly $2 million related to

these claims. For health insurance claims dating back to at least August 2010, and continuing through October 2015, Defendants claim they are owed $1,919,315.64 in overpayments for 423 individual claims. Defendants have already improperly offset at least $1,042,015.87 of this amount against claims submitted by the CarePoint Hospitals subsequent to October 2015.

2. Defendants provide health care insurance, administration, and/or benefits to insureds or plan participants pursuant to a variety of health care benefit plans and policies of insurance, including employer-sponsored benefit plans, government-sponsored benefit plans, and individual health benefit plans ("Plans").

3. As shown further below, in violation of their duties under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq*., and state law, Defendants have failed and refused to pay the CarePoint Hospitals in full for health care services that the CarePoint Hospitals have provided to patients covered by the health care benefit plans and policies of insurance provided or administered by Defendants ("United Subscribers").

4. Specifically, between approximately July 26, 2010, and October 2, 2015, the CarePoint Hospitals treated approximately 433 United Subscribers at the CarePoint Hospitals and accordingly billed Defendants for the medical services provided to these United Subscribers. Defendants paid 100% of these claims without question.

5. Then, by correspondence dated October 6, 2015, and November 9, 2015, Defendants demanded repayment for alleged overpayments related to these 433 claims in the amount of $2,271,412.35, in some cases months or even years after the CarePoint Hospitals provided treatment to Defendants' subscribers. These repayment demands are wholly improper.

6. As just one example, CH provided emergency medical services from May 9, 2014 through May 18, 2014, to a patient who required emergent gallbladder surgery. Defendants paid

the claim in full for $203,355.82 on August 6, 2014. Then, nearly nine months later, UHG sent CH a letter demanding a refund of $110,510.11 based on an audit of the claim performed by UHG's third-party vendor, CERiS Payment Audit Services. (See Exhibit A attached hereto). The unsubstantiated basis provided for $106,335.87 of the demanded refund was for "R&C adjustments" that were an "excessive charge above R&C for item/service according to geographic area." (Id.). The full $110,510.11 was later unlawfully offset against future CarePoint Hospitals claims. (Id.).

7. The CarePoint Hospitals have attempted to exhaust all available administrative remedies available to them, as well as to obtain additional information and resolve the dispute with Defendants, largely without success. Although Defendants have since withdrawn their demands for recoupment of 10 claims, totaling $352,096.71, they have refused to withdraw their remaining recoupment demands, leaving a total of 423 claims for which Defendants have demanded recoupment from Plaintiffs in the amount of $1,919,315.64.

8. Moreover, of that $1,919,315.64, Defendants have already offset post-October 2015 CarePoint Hospital claims in the amount of $1,042,015.87.

9. Making matters worse, Defendants' have failed to provide the proper notice and opportunity for a full and fair review.

10. Defendants' pattern of paying claims, subsequently demanding recoupments, and improperly offsetting these amounts against post-October 2015 CarePoint Hospital Claims, is in clear violation of the terms of Defendants' plan(s) or policy(ies) of insurance covering the United Subscribers (referred to herein as the "Plans"), as well as state and federal law.

II. THE PARTIES

11. Plaintiff BMC is a limited liability company organized under the laws of the State of New Jersey. BMC operates a licensed general acute care hospital doing business as

CarePoint Health – Bayonne Medical Center, located at 29 E. 29th Street, Bayonne, New Jersey 07002.

12. Plaintiff CH is a limited liability company organized under the laws of the State of New Jersey. CH operates a licensed general acute care hospital doing business as CarePoint Health – Christ Hospital, located at 176 Palisade Avenue, Jersey City, New Jersey 07306.

13. Plaintiff HUMC is a limited liability company organized under the laws of the State of New Jersey. HUMC operates a licensed general acute care hospital doing business as CarePoint Health -- Hoboken University Medical Center, located at 308 Willow Avenue, Hoboken, New Jersey 07030.

14. Defendant UHS is a corporation of the State of Minnesota with its principal place of business located at 9700 Health Care Lane, Minnetonka, Minnesota 55343.

15. Defendant Optum is a corporation of the State of Delaware with its principal place of business located at 11000 Optum Circle, Eden Prairie, MN 55344.

16. Defendant UHG is a corporation of the State of Delaware with its principal place of business located 9900 Bren Rd E. Minnetonka, MN, 55343.

17. Defendants are in the business of providing health benefit plans and policies of health insurance, including individual health benefit plans, employer-sponsored group health plans, and government-sponsored health benefit plans, including, but not limited to, the plans that covered the treatment received by the United Subscribers.

III. JURISDICTION AND VENUE

18. The Court has federal question subject matter jurisdiction over this matter pursuant to 28 U.S.C. § 1331, as the CarePoint Hospitals assert claims against Defendants, in Counts One, Two, and Three, under the Employee Retirement Income Security Act of 1974

(“ERISA”), 29 U.S.C. § 1001 *et seq*.

19. This Court also has supplemental jurisdiction over the CarePoint Hospitals’ state law claims against Defendants, in Counts Four through Ten, because these claims are so related to the CarePoint Hospitals’ federal claims that the CarePoint Hospitals’ state law claims form a part of the same case or controversy under Article III of the United States Constitution. As such, the Court has supplemental jurisdiction over these claims pursuant to 28 U.S.C. § 1367(a).

20. Furthermore, this Court has subject matter jurisdiction under 28 U.S.C. § 1332(a) because this is an action between citizens of different states and the matter in controversy exceeds the sum or value of $75,000.00, exclusive of interest and costs.

21. This Court has personal jurisdiction over the Defendants because, at all times material hereto, Defendants carried on one or more businesses or business ventures in this judicial district; there is the requisite nexus between the business(es) and this action; and Defendants engaged in substantial and not isolated activity within this judicial district.

22. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)(2), because a substantial portion of the events giving rise to this action arose in this District.

IV. GENERAL ALLEGATIONS

A. The CarePoint Hospitals.

23. BMC is a 278-bed, fully accredited, acute care hospital that provides quality, comprehensive, community-based health care services to more than 70,000 people annually. Its facilities include 19 full-service emergency room bays, 205 medical/surgical beds, 10 obstetrical beds, 17 pediatric beds, 14 adult ICU/CCU beds, and 15 adult, acute psychiatric beds. The service complement consists of six inpatient operating rooms, two cystoscopy rooms, one full-service cardiac catheterization lab, 12 chronic hemodialysis stations, one MRI unit, emergency

angioplasty services, elective angioplasty, two hyperbaric chamber unites, and a PET-CT diagnostic imaging unit.

24. CH is a 376-bed fully accredited acute care hospital. With a highly-qualified medical team – including more than 500 doctors with specialties ranging from allergies to vascular surgery – CH offers a full spectrum of services and has been recognized for excellence in cardiovascular, respiratory, and newborn care. As a state-certified Stroke Center and Primary Angioplasty Center, CH provides lifesaving emergency interventions with outcomes that rank among the best in New Jersey. CH is affiliated by common ownership with the principal owners of BMC.

25. HUMC is a 333-bed fully accredited general acute care hospital. HUMC provides advanced medical technologies in support of its medical staff, nursing team, and other caregivers, to enable state-of-the-art care to citizens of Hoboken and the surrounding communities. HUMC offers excellence in emergency medicine in the 34-bay emergency room and the dedicated OB/GYN ED; inpatient rehabilitation; transitional care' child and adult behavioral health' women's care; wound care; and numerous surgical subspecialties. The American Heart and Stroke Association awarded the Silver Award to HUMC for its dedication to improving quality of care for stroke patients. Overall, HUMC was ranked in the top ten hospitals in New Jersey for care quality among all hospitals in the state with 350 beds or fewer. HUMC is also affiliated by common ownership with the principal owners of BMC.

26. The CarePoint Hospitals and the independent physicians attending to patients at the hospitals are required by law to provide emergency/urgent care to any patient regardless of the patient's ability to pay and regardless of source of insurance payment. A patient's ability to pay in no way affects or impedes the CarePoint Hospitals' delivery of emergency health care.

B. The CarePoint Hospitals' Out-of-Network Status.

27. Health care providers are either "in-network" or "out-of-network" with respect to insurance carriers. "In-network" or "participating" providers are those who contract with health insurers that require them to accept discounted negotiated rates as payment in full for covered services.

28. "Out-of-network" or "non-participating" providers are those that do not have contracts with insurance carriers to accept discounted rates and, instead, set their own fees for services based on a percentage of charges. The CarePoint Hospitals are out-of-network providers.

D. United Subscribers Regularly Seek Treatment at the CarePoint Hospitals for which United Must Reimburse Plaintiffs under the Terms of its Plans and State Emergency Care mandates.

29. Despite the CarePoint Hospitals' out-of-network status, United Subscribers regularly seek treatment at the CarePoint Hospitals. Indeed, the CarePoint Hospitals have treated thousands of United Subscribers since July 2010. In many cases, United Subscribers pay significantly higher premiums for the inclusion of "out-of-network" benefits in their Plans. Patients are willing to pay significantly higher health care premiums in order to have access to out-of-network medical providers and obtain necessary medical services from the medical providers and medical facilities of their choice.

30. Upon information and belief, all of the Plans require United to reimburse the CarePoint Hospitals for their total billed charges, less applicable in-network patient responsibility, for emergency/urgent care that the CarePoint Hospitals provide to United Subscribers.

31. Of the 423 claims for which Defendants continue to seek recoupment from the CarePoint Hospitals, at least approximately 241 claims in the amount of $1,228,300.22, or approximately 64% of the total claims, relate to claims for emergency services. Some or all of the remaining claims are non-emergency claims.

32. Moreover, upon information and belief, many of Defendants' Plans covering United Subscribers specifically provide "out-of-network" benefits for services rendered by out-of-network hospitals such as the CarePoint Hospitals. These Plans require United to reimburse the CarePoint Hospitals for elective care that the CarePoint Hospitals provide to United Subscribers at the usual, customary, and reasonable rates for such elective care. The United Subscribers are responsible for the balance, if any, of CarePoint Hospitals' billed charges for such Elective care.

33. Further, New Jersey law requires that hospitals provide emergency/urgent care to all patients, regardless of ability to pay. This "take-all-comers" statute mandates that "[n]o hospital shall deny any admission or appropriate service to a Patient on the basis of that Patient's ability to pay or source of payment." N.J.S.A. § 26:2H-18.64. Violation of this provision subjects a hospital to a civil penalty of $10,000 for each violation.

34. New Jersey regulations mandate that a hospital provide an appropriate medical screening examination to all individuals who come to an emergency department with what they believe to be an emergent or urgent condition. N.J.A.C. § 8:43G-12.7(c).

35. To ensure access to emergency care regardless of a patient's type of insurance, New Jersey law requires healthcare insurers to specifically notify their subscribers that they are entitled to have "access" and "payment of appropriate benefits" for emergency conditions on a "24 hours a day" and "seven days a week" basis. N.J.A.C. § 11:24A-2.5(b)(2).

36. New Jersey law also provides that an insurance carrier must pay for the services provided by the hospital and do so promptly. This process begins with the requirement that the insurance carrier acknowledge receipt of all claims within two (2) working days, if the claim is submitted electronically, or within fifteen (15) working days, if the claim is submitted by way of written notice. See N.J.S.A. § 17:48E-10.1(d)(1).

37. New Jersey law provides that an insurance carrier must pay claims within thirty (3) days after the insurance carrier receives the claim when submitted electronically, or forty (40) days after received non-electronically, provided the following conditions apply:

a) The health care provider is eligible at the date of service;

b) The person who received the health care service was covered on the date of service;

c) the claim is for a service or supply covered under the health benefits plan;

d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c. 352 (C.17B:30-51); and

e) the payer has no reason to believe that the claim has been submitted fraudulently.

38. Accordingly, when a nonparticipating provider – for example, an out-of-network hospital – receives an assignment of the right to payment from a covered person, the insurance carrier is required by law to pay the hospital. See N.J.S.A. § 17:48E-10.1(d)(1).

39. United initially paid the full amount of the 423 claims without issue in order to appear compliant with the requirements of N.J.S.A. § 17:48E. However, many months, and in some cases, years later, as discussed below in more detail, United actively sought, without a substantiated basis, to recoup nearly $2 million related to these claims through offsets against

future CarePoint Hospital claims. In fact, United recouped over $1 million of these claims leaving the CarePoint Hospitals with no recourse and forcing the CarePoint Hospitals to initiate this lawsuit.

E. The CarePoint Hospitals Receive Complete Assignments of Benefits from United Subscribers for the Treatment that the CarePoint Hospitals Provide to United Subscribers.

40. Due to the CarePoint Hospitals' out-of-network status with United, each CarePoint hospital had no contract with United setting forth the terms under which United would pay for services that the CarePoint Hospitals provide to patients who are United Subscribers.

41. Rather, as out-of-network providers, the CarePoint Hospitals provide healthcare services to all persons, including, but not limited to, persons whose Plans allow them to receive services from providers who do not participate in their respective carrier's insurance network.

42. Under the terms of most Plans that provide coverage for out-of-network care, a patient is responsible for the payment of "coinsurance," a percentage of the out-of-network provider's charge for which the patient is responsible.

43. Upon registration at the CarePoint Hospitals, all patients, including United Subscribers, execute a form titled "Assignment of Insurance Benefits/Direct Payment/Authorized Representative/Agent" (the "AOB Contract"), among other documents. In the AOB Contract, United Subscribers assign to the CarePoint Hospitals their rights to benefits under Defendants' Plans.

44. The United Subscribers at issue signed one of two versions of the AOB Contract.

45. The first version of the AOB Contract provided for the assignment to the CarePoint Hospitals of all rights, benefits, and causes of action under a United Plan as follows:

> I HEREBY ASSIGN TO THE HOSPITAL, ALL OF MY RIGHTS, BENEFITS, PRIVILEGES, PROTECTIONS, CLAIMS, CAUSES OF

> ACTION, INTERESTS OR RECOVERY, TO ANY AND ALL RIGHTS, BENEFITS, PRIVILEGES, PROTECTIONS, CLAIMS, CAUSES OF ACTIONS, INTERESTS, OR RECOVERY OF ANY TYPE WHATSOEVER RECEIVABLE BY ME OR ON MY BEHALF ARISING OUT OF ANY POLICY OF INSURANCE, PLAN, TRUST, FUND, OR OTHERWISE PROVIDING HEALTH CARE COVERAGE OF ANY TYPE TO ME (OR TO ANY OTHER THIRD PARTY RESPONSIBLE FOR ME) FOR THE CHARGES FOR SERVICE RENDERED TO ME BY THE HOSPITAL. THIS INCLUDES, WITHOUT LIMITATION, ANY PRIVATE OR GROUP HEALTH/HOSPITALIZATION PLAN. AUTOMOBILE LIABILITY, GENERAL LIABILITY, PERSONAL INJURY PROTECTION, MEDICAL PAYMENTS, UNINSURED OR UNDERINSURED MOTOR VEHICLES BENEFITS, SETTLEMENTS/JUDGMENTS/VERDICTS, SELF-FUNDED PLAN, TRUST, WORKERS COMPENSATION, MEWA, COLLECTIVE, OR ANY OTHER THIRD-PARTY PAYOR PROVIDING HEALTH CARE COVERAGE OF ANY TYPE TO ME (OR TO ANY OTHER THIRD PARTY RESPONSIBLE FOR ME) FOR THE CHARGES FOR SERVICES RENDERED TO ME BY THE HOSPITAL [COLLECTIVELY, 'COVERAGE SOURCE'].

46. The second, slightly modified version of the AOB Contract contained the same language as the above, but added the following language:

> **THIS IS A DIRECT ASSIGNMENT OF ANY AND ALL OF MY RIGHTS TO RECEIVE BENEFITS ARISING OUT OF ANY COVERAGE SOURCE.** I UNDERSTAND THAT THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE. THIS ASSIGNMENT OF BENEFITS FULLY AND COMPLETELY ENCOMPASSES ANY LEGAL CLAIM I MAY HAVE AGAINST ANY COVERAGE SOURCE, INCLUDING, BUT NOT LIMITED TO, MY RIGHTS TO APPEAL ANY DENIAL OF BENEFITS ON MY BEHALF, TO REQUEST AND OBTAIN PLAN DOCUMENTS, TO PURSUE LEGAL ACTION AGAINST ANY COVERAGE SOURCE, AND/OR TO FILE A COMPLAINT WITH THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE.

47. Both versions of the AOB Contracts also provided for payment of any benefits directly to the CarePoint Hospitals:

> I AUTHORIZE AND DIRECT PAYMENT BE MADE BY ANY AND ALL COVERAGE SOURCE DIRECTLY TO THE HOSPITAL OF ALL BENEFITS, PAYMENTS, MONIES, CHECKS, FUNDS, WIRE TRANSFERS OR RECOVERY OF ANY KIND WHATSOEVER FROM ANY COVERAGE SOURCE. I ALSO AGREE TO ASSIST THE HOSPITAL IN PURSUING PAYMENT FROM ANY COVERAGE SOURCE. THIS INCLUDES, WITHOUT LIMITATION, SIGNING DOCUMENTS REQUESTED OR NEEDED TO PURSUE CLAIMS AND APPEALS, GETTING DOCUMENTS FROM COVERAGE SOURCE, OR OTHERWISE TO SUPPORT PAYMENT TO THE HOSPITAL.

48. Both versions of the AOB Contracts also provide for the CarePoint Hospitals to act as the United Subscriber/Patient's authorized agent and representative to pursue actions to recover benefits under a United Plan:

> I HEREBY AUTHORIZE AND DESIGNATE THE HOSPITAL, AS MY AUTHORIZED AGENT AND REPRESENTATIVE TO ACT ON MY BEHALF WITH RESPECT TO ALL MATTERS RELATED TO ALL OF MY RIGHTS, BENEFITS, PRIVILEGES, PROTECTIONS, CLAIMS, CAUSES OF ACTION, INTERESTS OR RECOVERY ARISING OUT OF ANY COVERAGE SOURCE. THIS INCLUDES, WITHOUT LIMITATION, THE HOSPITAL REQUESTING VERIFICATION OF COVERAGE/PRE-CERTIFICATION/AUTHORIZATION, FILING PRE-SERVICE AND POST-SERVICE CLAIMS AND APPEALS, RECEIVING ALL INFORMATION, DOCUMENTATION, SUMMARY PLAN DESCRIPTIONS, BARGAINING AGREEMENTS, TRUST AGREEMENTS, CONTRACTS, AND ANY INSTRUMENTS UNDER WHICH THE PLAN IS ESTABLISHED OR OPERATED, AS WELL AS RECEIVING ANY POLICIES, PROCEDURES, RULES, GUIDELINES, PROTOCOLS OR OTHER CRITERIA CONSIDERED BY THE COVERAGE SOURCE, IN CONNECTION WITH ANY CLAIMS, APPEALS, OR NOTIFICATIONS RELATED TO CLAIMS OR APPEALS.

49. Finally, both versions of the AOB Contracts provide, in part, that the patient is responsible for the payment of coinsurance and other charges not paid by the patient's Plan:

> I UNDERSTAND THAT I AM FINANCIALLY AND LEGALLY RESPONSIBLE FOR CHARGES NOT COVERED IN FULL BY THE ASSIGNMENT OF BENEFITS …, INCLUDING, BUT NOT LIMITED TO, ANY DEDUCTIBLES, COPAYMENTS, AND COINSURANCE AMOUNTS PROVIDED UNDER ANY COVERAGE SOURCE; AND CHARGES FOR WHICH THERE IS NO COVERAGE SOURCE.

F. Defendants' Deceptive and Improper Payment Practices.

50. Upon information and belief, Defendants have engaged and continue to engage in deceptive payment practices. Defendants market their Plans to consumers to include both in-network and out-of-network insurance coverage for emergency and elective medically necessary treatment. Members of the public who enroll in such plans reasonably rely on the fact that medically necessary treatment expenses will be covered by their health insurance plan issued by Defendants.

51. Defendants have paid and continue to pay claims submitted by the CarePoint Hospitals to Defendants for reimbursement for medically necessary treatment, without question and with no request for additional documentation prior to payment.

52. After the claims are paid in full, and long after the treatment has been provided and completed, Defendants retain purported third-party claims "auditors" to manufacture false reasons for demanding that the CarePoint Hospitals reimburse Defendants for the treatment that the CarePoint Hospitals have provided to Defendants' subscribers.

53. Among other tactics employed by these so-called "auditors," long after the treatment has been provided and payment has been made, the "auditors" will suddenly demand itemized bills for claims for services that the CarePoint Hospitals provided to these patients. Although the CarePoint Hospitals have no legal obligation to provide such information, the

"auditors" often circumvent Plaintiffs' dedicated revenue cycle consultants and seek and obtain the itemized bills directly from the CarePoint Hospitals.

54. The "auditors" then cite provisions of the itemized bills to manufacture a reason to argue that an overpayment on the claim has been made, and demand that the CarePoint Hospitals repay all or substantial portions of the claim. In fact, and described more fully below, the overpayment demands have no basis in law or fact or in the terms of the applicable Plans.

55. Even worse, the purported overpayment demands fail to provide the CarePoint Hospitals with any detailed explanation, calculation or records in support of the alleged overpayments. What is more, the purported overpayment demands do not afford sufficient time to allow the CarePoint Hospitals to adequately investigate the alleged demands.

G. Defendants' Unsubstantiated Repayment Demands and Improper Recoupment Related to the 423 Claims.

56. On October 6, 2015, the CarePoint Hospitals received a spreadsheet from Defendants for 144 claims and a demand of $1,543,741.4. (See Exhibit B attached hereto). Then, 18 days later on November 5, 2015, the CarePoint Hospitals received another spreadsheet demanding an overpayment of an additional $727,670.93 related to another 289 coupled with a brief explanation of the basis for recoupment. (See Exhibit C attached hereto). Defendants provided no detailed explanation, calculation or records with respect to their request to offset $2,271,412.35, and began offsets despite the CarePoint Hospitals' initial request to allow them time to further appeal the Defendants' adverse benefit determinations.

57. To date, Defendants have offset at least $1,042,015.87 against post-October 2015 CarePoint claims.

58. As explained above, Defendants later withdrew their repayment demands for 10 claims in the amount of $352,096.71 as a result of additional appeals. (See Exhibit D attached hereto). Defendants' repayment demand was therefore reduced to $1,919,315.64

59. While Defendants later provided Summary Plan Descriptions ("SPD") and Certificates of Coverage ("COC") for 29 of the 423 claims, as well as a handful of recoupment notification, audit and appeal resolution letters, this production failed to provide ***any*** detailed explanation, calculation or record with respect to Defendants' request to offset and completed offset of the claims properly due and owing to the CarePoint Hospitals.

60. For example, Defendants wrongfully recouped $341,359.91 of the $358,133.11 previously paid related to Patient 1, stating in the Defendants' spreadsheet that the claim "should have paid at the Maximum Non-Network Reimbursement Program (MNRP) rate of 15537.00 minus members coinsurance." (See Exhibit B at 16). No such rate is disclosed in Patient 1's SPD or any other documentation provided to CarePoint related to this claim. Defendants' Appeal Resolution Letter provided no additional information, stating "[w]e appreciate your concern however we believe we are entitled to the refund as requested. There was an executive decision to pay the claim at the MNRP rates and per authorization #103905841." (See Exhibit E attached hereto). Defendants provided additional justification for Patient 1's recoupment demand asserting that the claim for the medically necessary treatment "was not billed as an emergency and therefore, the claim should have paid at out of network rates." (See Exhibit F attached hereto). Review of Patient 1's SPD, however, reveals that non-emergency services should be paid at 60%, with a 40% coinsurance rate after the patient has met their deductible. (See Exhibit G attached hereto). It is impossible for the CarePoint Hospitals to determine, therefore, how or why Defendants wrongfully recouped 95% of the total paid on this claim.

61. As additional examples, Defendants have provided insufficient information supporting its claimed recoupments of $291,056.82 out of the $528,712.30 previously paid on the 11 claims listed on Exhibit H attached hereto. The audit letters for these claims list several reduced items and disallowed services, but fail to explain how the reasonable and customary rate was determined, what geographic area was relied upon, and provide no citation to a statute. For example, the audit letter for Patient 2 states that charges are disallowed as "excessive charge above R&C for item/service according to geographic area," "item/service is redundant from basic charge" and "routine nursing function is not separately billable." (See Exhibit I attached hereto).

62. The United spreadsheet provides no insight beyond the cryptic and conclusory statement that, "Itemization Verification and Charge Audit was completed by CERiS Payment Audit Services and an overpayment was identified. Please reference the audit findings previously provided to you." (See Exhibit H).

63. Finally, the appeal resolution letters again provide no information other than the conclusory statements that Defendants, "in the review of the documentation submitted, did not find any information which would alter the original findings on this claim." (See Exhibit J).

H. Defendants Violate the Terms of the Applicable Plans.

64. Upon information and belief, all of the Plans require reimbursement of medical expenses incurred by United Subscribers at usual, customary, and reasonable rates. As reflected above, the CarePoint Hospitals' total billed charges reflect the usual, customary, and reasonable rates for the particular medical services provided at the CarePoint Hospitals. Defendants' payment of the 423 CarePoint Hospital claims in full without question, then many months, and

sometimes years later, demanding recoupment without any discernable basis, falls far short of the usual, customary, and reasonable reimbursement rates required under the Plans.

65. Significantly, as described above, United Subscribers who seek treatment at the CarePoint Hospitals pay higher premiums, at times substantially higher premiums, in order to have the right under the Plans to receive medical treatment from the provider of their choice, including from out-of-network providers such as the CarePoint Hospitals. They bargain for and expect that payment be made at the providers' usual, customary, and reasonable rates. Defendants' payment of the 423 CarePoint Hospital claims in full without question, then many months, and sometimes years later, demanding recoupment without any discernable basis, falls far below these reasonable expectations.

66. Defendants acted as the plan administrators and as fiduciaries to the beneficiaries for each of the claims at issue in this case. Defendants exercised discretion, authority, control and oversight in determining if plan benefits would be paid and the amounts of plan benefits that would be paid. Defendants' administration of these claims resulted in the payment of 100% of these claims, and then, through their demand for repayment, resulted in nearly $2 million of adverse benefit determinations.

J. The CarePoint Hospitals Exhaust Available Internal Appeals Remedies.

67. Moreover, Defendants have only supplied to the CarePoint Hospitals a handful of the Plan SPDs and COCs covering the United Subscribers, and upon information and belief, the CarePoint Hospitals have exhausted or are in the process of exhausting, all available appeals avenues under those and the remaining United Subscriber Plans in an effort to convince Defendants to forego its repayment demands, and reimburse CarePoint for the offsets made to date, for the extensive treatment that the CarePoint Hospitals provided to the United Subscribers.

68. Among other things, for certain claims, the CarePoint Hospitals follows the processes set forth in a document prepared by Defendants and entitled, "UnitedHealthcare: Claim Reconsideration Request Reference Guide." This document specifies that "[a] Claim Reconsideration Request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration Request, we review whether a claim was paid correctly, including if your provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced."

69. In addition, where a "Claim Reconsideration Request" has either not been submitted or has been rejected, the CarePoint Hospitals follows the appeals processes set forth in a document prepared by Defendants and entitled, "UnitedHealthcare Community Plan: Appeal Request Form." This form states that it "is to be completed by Physicians, Hospitals, or other health care professionals who wish to request a clinical appeal of an adverse medical determination or administrative claim made by UnitedHealthcare Community Plan."

70. Moreover, additional efforts to appeal the 423 claims would be futile, as evidenced by Defendants' offsets against post-October 2015 CarePoint Hospital claims in the amount of at least $1,042,015.87.

71. Despite exhausting the appeal procedures set forth in Defendants' own documents, Defendants maintain that they are entitled to reimbursement or the offsets already made against post-October 2015 CarePoint Hospital claims for a total of approximately $2 million for services provided by the CarePoint Hospitals to the United Subscribers from July 2010 through October 2015.

72. Moreover, despite exhausting the appeal procedures set forth in Defendants' own documents, Defendants have failed to adequately explain the basis for improper demands for

repayment and offsets against post-October 2015 CarePoint Hospital claims. In particular, Defendants have failed or refused to: (a) provide the specific reason or reasons for the denial of claims; (b) provide the specific plan provisions relied upon to support the denials; (c) provide the specific rule, guideline or protocol relied upon in making the decision to deny claims; (d) describe any additional material or information necessary to perfect a claim, such as the appropriate diagnosis/treatment code; and (e) notify the relevant parties that they are entitled to have, free of charge, all documents, records and other information relevant to the claims for benefits.

73. The instant action is timely commenced well within six years after the CarePoint Hospitals were notified by Defendants that they were demanding repayments from the CarePoint Hospitals on their claims for reimbursement for the services that the CarePoint Hospitals provided to United Subscribers, and otherwise within six years after each of the CarePoint Hospitals' claims against Defendants accrued.

V. CAUSES OF ACTION

COUNT ONE

(Breach of Plan Provisions for Benefits in Violation of ERISA § 502(a)(1)(B))

74. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

75. The CarePoint Hospitals have standing to pursue claims under ERISA as an assignee and authorized representative of the United Subscribers' claims under the Plans.

76. As the assignee of the Plans, the CarePoint Hospitals are entitled to reimbursement under the ERISA Plans for the hospital services provided to the United Subscribers at the CarePoint Hospitals.

77. All of the Plans require reimbursement of medical expenses incurred by United Subscribers at usual, customary, and reasonable rates. Defendants have breached the terms of the Plans by demanding repayment and improperly offsetting alleged overpayments against post-October 2015 CarePoint Hospital claims for charges covered by the Plans, in violation of ERISA 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). These breaches include, among other things, refusing to pay the usual, customary, and/or reasonable charges, or the prevailing fees or recognized charges, for medically-necessary procedures and services performed at the CarePoint Hospitals.

78. As a result of, among other acts, Defendants' numerous procedural and substantive violations of ERISA, any appeals are deemed exhausted or excused, and the CarePoint Hospitals are entitled to have this Court undertake a *de novo* review of the issues raised herein.

79. Pursuant to 29 U.S.C. § 1132(a)(1)(B), the CarePoint Hospitals are entitled to recover unpaid/underpaid benefits from Defendants. The CarePoint Hospitals are also entitled to declaratory and injunctive relief to enforce the terms of the Plans and to clarify its right to future benefits under such plans, as well as attorneys' fees.

COUNT TWO

(Violation of Fiduciary Duties of Loyalty and Due Care in Violation of ERISA)

80. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

81. 29 U.S.C. § 1132(a)(3) states that a civil action may be brought by "a participant, beneficiary, or fiduciary to (A) enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to

redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

82. The CarePoint Hospitals, as assignees of ERISA members and beneficiaries under the insurance plans, are entitled to assert a claim for relief for Defendants' breach of fiduciary duties of loyalty and care and for failure to follow plan documents under 29 U.S.C. § 1104(a)(1)(B) and (D).

83. Defendants exercised discretion, control, authority and oversight in determining whether plan benefits would be paid and the amounts of plan benefits that would be paid.

84. As ERISA fiduciaries, Defendants owed the CarePoint Hospitals a duty of care, defined as an obligation to act prudently, with the care, skill, prudence and diligence that a prudent fiduciary would use in the conduct of an enterprise of like character. Further, as fiduciaries, Defendants were required to ensure that they were acting in accordance with the documents and instruments governing the Plans, and in accordance with ERISA § 404(a)(l)(B) and (D), 29 U.S.C. § 1104(a)(l)(B) and (D). In failing to act prudently, and in failing to act in accordance with the documents governing the Plans, Defendants have violated their fiduciary duty of care.

85. As fiduciaries, Defendants also owed the CarePoint Hospitals a duty of loyalty, defined as an obligation to make decisions in the interest of its beneficiaries, and to avoid self-dealing or financial arrangements that benefit the fiduciary at the expense of members, in accordance with ERISA § 404(a)(l)(A), 29 U.S.C. § 1104(a)(l)(A) and ERISA § 406, 29 U.S.C. § 1106. Thus, Defendants could not make benefit determinations for the purpose of saving money at the expense of the United Subscribers.

86. Defendants have violated their fiduciary duty of loyalty to the CarePoint Hospitals by, among other things, demanding repayments and offsetting such amounts against post-October 2015 claims for hospital services provided at the CarePoint Hospitals for their own benefit, and at the expense of United Subscribers. In addition, Defendants violated their fiduciary duty of loyalty by failing to inform the CarePoint Hospitals, as assignees of the United Subscribers, of material information.

87. The CarePoint Hospitals have standing to pursue claims under ERISA as assignees and authorized representatives of the United Subscribers' claims.

88. The CarePoint Hospitals are entitled to relief to remedy Defendants' violation of their fiduciary duties under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), including declaratory and injunctive relief.

COUNT THREE

(Denial of Full and Fair Review in Violation of ERISA § 503)

89. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

90. As assignees and authorized representatives of the United Subscribers' claims, the CarePoint Hospitals are entitled to receive protection under ERISA, including (a) a "full and fair review" of all claims denied by Defendants; and (b) compliance by Defendants with applicable claims procedure regulations.

91. Although Defendants are obligated to provide a "full and fair review" of denied claims pursuant to ERISA § 503, 29 U.S.C. § 1133 and applicable regulations, including 29 C.F.R. § 2560.503-1 and 29 C.F.R. § 2590.715-2719, Defendants have failed to do so by, among other actions: refusing to provide the specific reason or reasons for the denial of claims; refusing to provide the specific plan provisions relied upon to support its denial; refusing to

provide the specific rule, guideline or protocol relied upon in making the decision to deny claims; refusing to describe any additional material or information necessary to perfect a claim, such as the appropriate diagnosis/treatment code; and refusing to notify the relevant parties that they are entitled to have, free of charge, all documents, records and other information relevant to the claims for benefits; and refusing to provide a statement describing any voluntary appeals procedure available, or a description of all required information to be given in connection with that procedure. By failing to comply with the ERISA claims procedures regulations, Defendants failed to provide a reasonable claims procedure.

92. Because Defendants have failed to comply with the substantive and procedural requirements of ERISA, any administrative remedies are deemed exhausted pursuant to 29 C.F.R. § 2560.503-1(l) and 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1). Exhaustion is also excused because it would be futile to pursue administrative remedies, as Defendants do not acknowledge any basis for their denials and thus offer no meaningful administrative process for challenging their denials.

93. The CarePoint Hospitals have been harmed by Defendants' failure to provide a full and fair review of appeals submitted under ERISA § 503, 29 U.S.C. § 1133, and by Defendants' failures to disclose information relevant to appeals and to comply with applicable claims procedure regulations.

94. The CarePoint Hospitals are entitled to relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), including declaratory and injunctive relief, to remedy Defendants' failures to provide a full and fair review, to disclose information relevant to appeals, and to comply with applicable claims procedure regulations.

COUNT FOUR

(Breach of Contract – non-ERISA)

95. The CarePoint Hospitals incorporates by reference all of the foregoing allegations as if set forth at length herein.

96. To the extent that some of the Plans are not employee welfare benefit plans governed by ERISA, they are nonetheless valid and enforceable insurance contracts.

97. As set forth more fully above, upon information and belief, all of the Plans require reimbursement of medical expenses incurred by United Subscribers at usual, customary, and reasonable rates. Further, under the terms of the Plans, United Subscribers are entitled to coverage for the services that they received from the CarePoint Hospitals.

98. By virtue of the "Assignment of Benefits" forms executed by United Subscribers, the CarePoint Hospitals were assigned the right to receive reimbursement under the Plans for the services that it rendered to the United Subscribers. Pursuant to said assignments of benefits, Defendants are contractually obligated to reimburse the CarePoint Hospitals for these services.

99. Defendants failed to make payment of benefits to the CarePoint Hospitals in the manner and amounts required under the terms of the Plans.

100. As set forth more fully above, upon information and belief, the Plans did not prohibit the United Subscribers from assigning their rights to benefits under the Plans to the CarePoint Hospitals, including the right of direct payment of benefits under the Plans to the CarePoint Hospitals.

101. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, Defendants have waived any purported anti-assignment provisions, have ratified the assignment of benefits to the CarePoint Hospitals, and/or

are estopped from using any purported anti-assignment provisions against the CarePoint Hospitals due to their course of dealing with and statements to the CarePoint Hospitals as out-of-network providers, discussed more fully above.

102. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, any such purported anti-assignment prohibitions are unenforceable as, among other things, contrary to public policy, as adhesion contracts, and/or due to a lack of privity with the CarePoint Hospitals.

103. As the result of Defendants' failures to comply with the terms of the Plans, the CarePoint Hospitals, as assignees of the United Subscribers, have suffered damages and lost benefits, for which they are entitled to damages from Defendants, including unpaid benefits, restitution, interest, and other contractual damages sustained by the CarePoint Hospitals.

COUNT FIVE

(Breach of the Duty of Good Faith and Fair Dealing – non-ERISA)

104. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

105. As set forth more fully above, if any of the Plans are not employee welfare benefit plans governed by ERISA, they are nonetheless valid and enforceable insurance contracts. As such, the Plans contain an implied duty of good faith and fair dealing.

106. Defendants, as the obligor under the Plans, owed the United Subscribers a duty of good faith and fair dealing with respect to said Plans.

107. As set forth more fully above, the United Subscribers received health care services at the CarePoint Hospitals and executed "Assignment of Benefit" forms, among other

documents, in which they assigned to the CarePoint Hospitals their right to benefits under the Plans for the services that the CarePoint Hospitals provided to the United Subscribers.

108. By virtue of these assignments, Defendants also owe this duty of good faith and fair dealing to the CarePoint Hospitals.

109. As set forth more fully above, upon information and belief, the Plans did not prohibit the United Subscribers from assigning their rights to benefits under the Plans to the CarePoint Hospitals, including the right of direct payment of benefits under the Plans to the CarePoint Hospitals.

110. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, Defendants have waived any purported anti-assignment provisions, have ratified the assignment of benefits to the CarePoint Hospitals, and/or are estopped from using any purported anti-assignment provisions against the CarePoint Hospitals due to their course of dealing with and statements to the CarePoint Hospitals as out-of-network providers, discussed more fully above.

111. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, any such purported anti-assignment prohibitions are unenforceable as, among other things, contrary to public policy, as adhesion contracts, and/or due to a lack of privity with the CarePoint Hospitals.

112. Defendants breached their duty of good faith and fair dealing owed to the CarePoint Hospitals, as assignees of rights and benefits under the Plans, in a number of ways, described more fully above.

113. Without limitation, Defendant's breaches include, but are not limited to, the following:

a. Defendants' demand for repayment and offsetting such amounts against post-October 2015 CarePoint Hospital claims relative to charges for the health care services the CarePoint Hospitals provided to the United Subscribers, when Defendants' liability for those amounts was reasonably clear;

b. Defendants' failures to provide the CarePoint Hospitals with adequate written explanations for the failure to reimburse all or a portion of the CarePoint Hospital claims for the services provided to United Subscribers, as is required under New Jersey law;

c. Defendants' failures to properly reimburse the CarePoint Hospitals' charges for the health care services provided to the United Subscribers, and their failures to provide adequate written explanations for the failure to pay all or a portion of such claims, within the statutorily proscribed time frames under New Jersey law;

d. Defendants' arbitrary methodology for determining whether and the amount to reimburse the CarePoint Hospitals for the services provided to United Subscribers;

e. Defendants' patently inadequate explanations for their demand for repayment offsets against post-October 2015 claims of the CarePoint Hospitals.

114. Defendants' conduct in derogation of their duty of good faith and fair dealing under the Plans has deprived the CarePoint Hospitals of their reasonable expectations and benefits as assignees of benefits under the Plans.

COUNT SIX

(Breach of Fiduciary Duty – non-ERISA)

115. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

116. At all relevant times, Defendants were the plan administrator, fiduciary, relevant party-in-interest, and/or the obligor for the Plans. As such, even if some of the Plans are not employee welfare benefit plans governed by ERISA, Defendants nonetheless owed and owe the United Subscribers fiduciary duties under the Plans.

117. As set forth more fully above, United Subscribers have received health care services at the CarePoint Hospitals and executed "Assignment of Benefits" forms, among other documents, in which they assigned to the CarePoint Hospitals their rights to benefits under the Plans for the services that the CarePoint Hospitals provided to the United Subscribers.

118. By virtue of these assignments, Defendants also owed and owe this fiduciary duty to the CarePoint Hospitals, as the beneficiaries under the Plans.

119. As set forth more fully above, upon information and belief, the Plans did not prohibit United Subscribers from assigning their rights to benefits under the Plans to the CarePoint Hospitals, including the right of direct payment of benefits under the Plans to the CarePoint Hospitals.

120. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, Defendants have waived any purported anti-assignment provisions, have ratified the assignment of benefits to the CarePoint Hospitals, and/or are estopped from using any purported anti-assignment provisions against the CarePoint Hospitals due to their course of dealing with and statements to the CarePoint Hospitals as out-of-network providers, discussed more fully above.

121. Moreover, as set forth more fully above, to the extent that the Plans prohibited the assignment of benefits to the CarePoint Hospitals, any such purported anti-assignment

prohibitions are unenforceable as, among other things, contrary to public policy, as adhesion contracts, and/or due to a lack of privity with the CarePoint Hospitals.

122. Defendants breached their fiduciary duties owed to the CarePoint Hospitals in a number of ways, described more fully above.

123. As the result of Defendants' violations of their fiduciary duties to the CarePoint Hospitals, the CarePoint Hospitals have suffered, and continues to suffer, substantial damages.

COUNT SEVEN

(Quantum Meruit)

124. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

125. The CarePoint Hospitals have conferred upon Defendants the benefit of providing treatment to United Subscribers.

126. At the times the CarePoint Hospitals treated the United Subscribers, the CarePoint Hospitals reasonably expected remuneration from Defendants in the form of its full billed charges minus any applicable patient responsibilities.

127. By offsetting the alleged overpayment amounts against post-October 2015 CarePoint Hospital claims for the treatment provided by the CarePoint Hospitals to United Subscribers, Defendants have been unjustly enriched.

128. As the result of Defendants unlawful, unjust, and wrongful acts, the CarePoint Hospitals suffered and continue to suffer damages, and it is owed restitution from Defendants.

COUNT EIGHT

(Promissory Estoppel)

129. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

130. Defendants represented to the CarePoint Hospitals that the medical treatment sought by the Patients at the CarePoint Hospitals was a covered procedure under the Plans, and that the fees associated with that treatment were Covered Charges under the Plans. Based on Defendants' statements that the patients seeking medical care and treatment had active coverage and benefits, the CarePoint Hospitals reasonably understood that some payment would be forthcoming for the hospital services provided at the CarePoint Hospitals related to these procedures.

131. The CarePoint Hospitals provided hospital services to United Subscribers in reliance on Defendants' statements regarding coverage and benefits. In the absence of Defendants' statements that they would make remuneration for the fees associated with this treatment, the CarePoint Hospitals would not have provided the hospital services. This reliance was foreseeable, as Defendants' representations were made in the context of telephone calls from the CarePoint Hospitals' billing agents to verify and pre-certify coverage prior to the hospital services being provided, and there was no ability for the CarePoint Hospitals to learn, separate and apart from Defendants' representations, whether Defendants considered the fees related to these hospital services to be covered charges under the relevant Plans.

132. As a result of the CarePoint Hospitals' reliance on Defendants' statements, Texas General has suffered and continues to suffer injury, including money damages, and injustice can only be avoided by Defendants honoring their previous promises.

COUNT NINE

(Temporary and Permanent Injunctive Relief)

133. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

134. Currently, Defendants are wrongfully demanding repayment for hundreds of claims for benefits submitted for hospital services provided at the CarePoint Hospitals. In so doing, Defendants have failed and are failing to comply with the terms of the Plans and their other obligations, including their obligations under ERISA.

135. Unless enjoined from doing so, Defendants will continue not to comply with the terms of the Plans and their other obligations, including under ERISA, to the CarePoint Hospitals' severe detriment. A monetary judgment in this case will only compensate the CarePoint Hospitals for past losses, and will not stop Defendants from continuing to confiscate the money earned by the CarePoint Hospitals and necessary to maintain its medical facility. The CarePoint Hospitals have no practical or adequate remedy, either administratively or at law, to avoid these future losses.

136. The CarePoint Hospitals are entitled to a preliminary and permanent injunction requiring Defendants to process claims for hospital services performed at the CarePoint Hospitals in accordance with the terms of the Plans, and requiring Defendants to stop demanding repayments and offsetting such amounts against future CarePoint Hospital claims for medically necessary services provided by the CarePoint Hospitals.

COUNT TEN

(Violation of New Jersey Consumer Fraud Act)

137. The CarePoint Hospitals incorporate by reference all of the foregoing allegations as if set forth at length herein.

138. BMC, HUMC, CHMG and Defendants are "persons" as defined by N.J.S.A. 56:8-1(d).

139. The hospital services and other medical services at issue in this case and Defendants' health insurance plans are all “merchandise” as defined by N.J.S.A. 56:8-1(c).

140. The sale of said merchandise to consumers are “sales” as defined by N.J.S.A. 56:8-1(e).

141. With the intent that consumers enroll in Defendants’ health insurance plans, Defendants have represented to consumers that such plans provide coverage for medically necessary treatment at both in-network and out-of-network healthcare facilities.

142. Upon information and belief, Defendants’ have marketed their out-of-network coverage to the public as an additional benefit included in their health insurance plans. Members of the public who enroll in such plans reasonably rely on the fact that medically necessary treatment expenses will be covered by their health insurance plans by Defendants.

143. Defendants’ practice of paying claims in full without question, and then hiring third-party auditors to manufacture false bases for Defendants’ repayment demands and improper offsets against future claims will continue to cause hundreds of patients, and the CarePoint Hospitals, as their assignees, an ascertainable loss.

144. On information and belief, Defendants knowingly and willfully induced patients into enrolling in their health insurance plans by representing that the plans provided coverage for out-of-network medically necessary treatment, and, at the time of patient enrollment, effectively concealed their practice of paying claims in full, and then hiring third-party auditors to manufacture false reasons for demanding that the CarePoint Hospitals reimburse Defendants for the treatment that the CarePoint Hospitals have provided to Defendants’ subscribers. .

145. Said representations and concealments are material to consumer decisions regarding which insurance plans to sign up for and which hospitals and affiliated medical professionals to use, and they constitute unlawful practices pursuant to N.J.S.A. 56:8-2.

146. As a result of Defendants' misrepresentations and concealments regarding their latent repayment demands and improper offsets of alleged overpayments against future health insurance claims, the CarePoint Hospitals have and will continue to suffer ascertainable losses of revenue.

147. In light of the foregoing, Defendants violated N.J.S.A. 56:8-1, *et seq.*

148. Within ten days of filing this Verified Complaint, Plaintiffs will mail a copy to the New Jersey Attorney General pursuant to N.J. S.A. 56:8-20.

149. The CarePoint Hospitals, as assignees of the United Subscribers, bring this action pursuant to N.J.S.A. 56:8-19, as persons that have suffered and will continue to suffer an ascertainable loss of money as a result of Defendants' unlawful practices, and in accordance therewith, the CarePoint Hospitals seek equitable relief, statutory treble damages, attorneys' fees, and court costs

VI. CONDITIONS PRECEDENT

150. All conditions precedent have been performed or have occurred.

VII. JURY DEMAND

151. Pursuant to Rule 38 of the Federal Rules of Civil Procedure, the CarePoint Hospitals hereby request a trial by jury on all issues so triable.

VIII. PRAYER FOR RELIEF

WHEREFORE, the CarePoint Hospitals demand judgment in its favor against Defendants as follows:

A. For a declaratory judgment by this Court finding that Defendants have breached the terms of the Plans with regard to out-of-network benefits and awarding damages for the claims offset against post-October 2015 CarePoint Hospital claims, as well as an award of injunctive and declaratory relief to prevent Defendants' continuing actions detailed herein;

B. For a declaratory judgment by this Court finding that Defendants failed to provide a "full and fair review" under § 503 of ERISA, 29 U.S.C. § 1133, and applicable claims procedure regulations, and that "deemed exhaustion" under such regulations is in effect as a result of Defendants' actions, as well as awarding injunctive, declaratory and other equitable relief to ensure compliance with ERISA and its claims procedure regulations;

C. For a declaratory judgment by this Court finding that Defendants violated their fiduciary duties under § 404 of ERISA, 29 U.S.C. § 1106, and awarding injunctive, declaratory and other equitable relief to ensure compliance with ERISA;

D. For an award of damages based on Defendants' misrepresentations and nondisclosures regarding the existence of benefits for these hospital services based on promissory estoppel, including any exemplary damages permitted by law;

E. For an injunction that temporarily and permanently enjoins Defendants from continuing to pursue their actions detailed herein, and ordering Defendants to pay benefits in accordance with the terms of the Plans and applicable law;

F. For an award of lost profits, contractual damages, and compensatory damages in such amounts as the proofs at trial shall show;

G. For an award of exemplary damages for Defendants' intentional and tortious conduct in such amounts as the proofs at trial will show;

H. For an award of restitution for amounts improperly offset against post-October 2015 CarePoint Hospital claims by Defendants;

I. For a declaratory judgment by this Court finding that Defendants have violated the terms of the relevant plans and/or policies of insurance covering the United Subscribers;

J. For a judgment that requires Defendants to make full payment on all previously offset claims amounts relating to services provided by the CarePoint Hospitals to the United Subscribers;

K. For a judgment that requires Defendants to pay the CarePoint Hospitals the benefit amounts as required under the Plans;

L. For an award of statutory treble damages;

M. For an award of punitive damages;

N. For an award of reasonable attorneys' fees, as provided by common law, federal or state statute, or equity;

O. For an award of filing fees and costs of suit;

P. For an award of pre-judgment and post-judgment interest as provided by common law, federal or state statute or rule, or equity; and

Q. For an award of all other relief to which Plaintiffs are entitled.

Respectfully submitted,

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